Provider Information Form for Non-Contracted Providers

Note: If you are currently contracted with Hennepin Health or have received an offer to contract with Hennepin Health, complete the Network Provider Information Form (PIF) found on our website at www.hennepinhealth.org.

Submit completed forms and any questions via email to hhnetworkmanagement@hennepin.us. **Remember to also include your W-9.** Please allow 30 business days for this information to be processed.

BUSINESS INFORMATION	
Legal Business Name *(as appears on W-9)*	
DBA Name	**Website Address**
Federal Tax ID	**Type-2 Business NPI/UMPI**

ELECTRONIC CLEARINGHOUSE INFORMATION

Hennepin Health accepts electronic claims submission and sends remittance advices through:

- Change Healthcare (formerly Emdeon): www.changehealthcare.com (877-271-0054)
- RelayHealth: www.relayhealth.com (888-743-8735)
- ClaimLynx: www.claimLynx.com (952-593-LYNX (5969))

If you are not already registered with these clearinghouses, please contact them via the telephone or website address provided.

Please complete the following regarding your claims submissions and remittance advices:

Electronic Claims Submission Type ☐ 837I ☐ 837P

☐ Change Healthcare (formerly Emdeon) ☐ ClaimLynx
☐ RelayHealth

Remittance Advice (835)

☐ Change Healthcare (formerly Emdeon) ☐ ClaimLynx
☐ RelayHealth ☐ Other

LOCATION INFORMATION			
Address	**City**	**State**	**Zip**
Primary Phone	**Fax**		

PRACTITIONER INFORMATION

Providers must be registered with the Minnesota Department of Human Services (DHS). Claims from providers not registered with DHS will be denied.

In the space below, please provide the practitioner information for those seeing Hennepin Health members.

Last Name	**First Name**	**Middle Initial**	**Title**
DOB (MM/DD/YYYY)	**Type 1 Individual NPI**	**SSN**	
Specialty	**State License #**		

Additional practitioner (if applicable)

Last Name	**First Name**	**Middle Initial**	**Title**
DOB (MM/DD/YYYY)	**Type 1 Individual NPI**	**SSN**	
Specialty	**State License #**		
Billing Contact *(name, email, phone)*			

Date of Form Completion